NOTICES OF SUPPLEMENTAL PROPOSED RULEMAKING

After an agency has filed a Notice of Proposed Rulemaking with the Secretary of State's Office for *Register* publication and the agency decides to make substantial changes to the rule after it is proposed, the agency must prepare a Notice of Supplemental Proposed Rulemaking for submission to the Office, and the Secretary of State shall publish the Notice under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.). Publication of the Notice of Supplemental Proposed Rulemaking shall appear in the *Register* before holding any oral proceedings (A.R.S. § 41-1022).

NOTICE OF SUPPLEMENTAL PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 1. DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

[R06-139]

PREAMBLE

1. *Register* citation and date for the original Notice of Proposed Rulemaking:

Notice of Proposed Rulemaking: 11 A.A.R. 5298, December 16, 2005

2.

Sections Affected	Rulemaking Action
Article 5	New Article
R9-1-501	New Section
R9-1-502	New Section
R9-1-503	New Section
R9-1-504	New Section
R9-1-505	New Section
R9-1-506	New Section

3. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 36-136(A)(7) and 36-136(F)

Implementing statutes: A.R.S. §§ 36-104(16), 36-2172(B), 36-2174(A), and 36-2907.06(D)

4. The name and address of agency personnel with whom persons may communicate regarding the rule:

Name: Myriam Vega, Office Chief

Address: Arizona Department of Health Services
Office of Health Systems Development
1740 W. Adams, Room 410
Phoenix, AZ 85007

Telephone: (602) 542-1219

Fax: (602) 542-2011

E-mail: vegami@azdhs.gov

Or

Name: Kathleen Phillips, Rules Administrator

Address: Arizona Department of Health Services
Office of Administrative Rules
1740 W. Adams, Room 202
Phoenix, AZ 85007

Telephone: (602) 542-1264

Fax: (602) 364-1150

E-mail: phillik@azdhs.gov

5. An explanation of the rule, including the agency's reasons for initiating the rule:

The Department of Health Services (Department) placed the existing sliding fee schedule Article, 9 A.A.C. 2, Article 1, in the Chapter labeled "Tobacco Tax-funded Programs" because the sliding fee schedule rule, R9-2-101, applied to the A.R.S. § 36-2907.06 primary care program funded under former A.R.S. § 36-2921. Former A.R.S. § 36-2921 allocated tobacco tax funds, including allocations to the primary care programs and other Department programs. Laws 2003, Chapter 265, § 30, retroactively effective to July 1, 2003, repealed all versions of A.R.S. § 36-2921. The state's general fund currently funds the programs.

In addition to the primary care program, Department programs, such as the primary care provider loan repayment program under A.R.S. § 36-2172 and 42 CFR Part 62[1], the rural private primary care provider program under A.R.S. § 36-2174, and the J-1 visa waiver program and the national interest waiver program under A.R.S. § 36-104(16), need to reference the sliding fee schedule rules. Therefore, the Department determined to make updated sliding fee schedule rules and to place them in 9 A.A.C. 1, Administration, as a new Article 5, Sliding Fee Schedules. The new Article includes R9-1-501, Definitions; R9-1-502, Family Member Determination; R9-1-503, Family Income Determination; R9-1-504, Sliding Fee Schedule Submission and Contents; R9-1-505, Sliding Fee Schedule Approval Time-frames; and R9-1-506, Fees Payable by Uninsured Individuals Under a Sliding Fee Schedule.

[[1] 42 CFR 62.55(c)(2) provides that a health professional who participates in a state loan repayment program receiving federal grants authorized by 42 U.S.C. 254q-1 shall "charge for his or her professional services at the usual and customary rate prevailing in the area in which such services are provided, except that if a person is unable to pay such charge, such person shall be charged at a reduced rate or not charged any fee."]

In this rulemaking, the Department is providing stakeholders and the public with clear, concise, and understandable rules for sliding fee schedules used by health care providers. The Department determined that hospital inpatient services or medical services at a correctional facility or detention facility should not be subject to a discount contained in a sliding fee schedule. Therefore, an individual or entity is not a provider for sliding fee schedule purposes (sliding-fee-schedule provider) when providing hospital inpatient services or medical services at a correctional facility or detention facility.

The Department determined that the new rules should include requirements for sliding fee schedules containing discounts for uninsured individuals that are expressed as flat fees as well as for sliding fee schedules containing discounts for uninsured individuals that are expressed as percentages of the usual fee for medical services (fee percentages). Sliding-fee-schedule providers must establish sliding fee schedules with flat fees or fee percentages for uninsured individuals with family incomes above 100 percent of the current federal poverty guidelines up to and including 200 percent of the current federal poverty guidelines. Like the rules as originally proposed, the supplemental proposed rules allow these providers to submit for the Department's approval a sliding fee schedule with fee percentages, a sliding fee schedule with flat fees, or both.

The Department determined that, for uninsured individuals with family incomes above 100 percent of the current federal poverty guidelines up to and including 200 percent of the federal poverty guidelines, a sliding fee schedule must contain at least three fee percentage levels or three flat fee levels that increase as family income increases. Like the rules as originally proposed, the supplemental proposed rules require at least three levels for individuals with family incomes above 100 percent of the current federal poverty guidelines up to and including 200 percent of the federal poverty guidelines. This requirement, which allows sliding-fee-schedule providers to specify the amount and the spread of the fee percentages or flat fees, gives providers flexibility in establishing fee schedules and is consistent with meaningful discounts for low income uninsured individuals.

Like the rules as originally proposed, the supplemental proposed rules require a sliding fee schedule to contain a 100 percent fee reduction or a $0 flat fee for uninsured individuals with family incomes at or below the current federal poverty guidelines. The Department also determined that sliding-fee-schedule providers can charge these uninsured individuals a single administrative fee that does not exceed $25. For uninsured individuals with family incomes above 100 percent of the federal poverty guidelines up to and including 200 percent of the federal poverty guidelines, providers may charge the single administrative fee only as an alternative to the fee calculated according to a sliding fee schedule. Charging a single administrative fee may increase providers' revenues, may reduce overuse of health care resources, and may increase the self-esteem of low income uninsured individuals who otherwise would not be charged for the services they receive. The Department believes that a single administrative fee of $25 or less is appropriate for low income uninsured individuals.

In a separate rulemaking the Department is repealing A.A.C. Title 9, Chapter 2, Tobacco Tax-funded Programs, including Article 1, Sliding-fee Schedule; and R9-2-101, Approval of Sliding-fee Schedule. The existing rule will remain in place until the effective date of the new rules.

6. An explanation of the substantial change which resulted in this supplemental notice:

After the Notice of Proposed Rulemaking was published the Department received three comments from the public. The comments and the Department's response to each comment are described in the following table.

Organization that Submitted the Comment	Comment Summary	Department Response
Maricopa Integrated Health System (MIHS)	1. Can a provider have multiple administrative fees? 2. MIHS does not understand the meaning of the "balance remaining" language in R9-1-506. 3. Can a provider waive a flat fee for patients with incomes above 100 percent of the Federal Poverty Guidelines (FPG) and not more than 200 percent of the FPG?	1. The Department will allow only a single administrative fee. 2. The Department agrees that R9-1-506(C) and (D) need clarification. 3. These rules address the sliding fee schedule requirements and do not address fee waiver by a provider.
Community Health Center of West Yavapai, Yavapai County	1. Can a provider charge patients with incomes at or below 100 percent of the FPG the administrative fee not to exceed $25? 2. Does a sliding fee schedule have to have at least three levels for patients with incomes above 100 percent of the FPG and not more than 200 percent of the FPG? 3. If so, then the commenter is okay with these rules.	1. Yes 2. Yes 3. The Department appreciates the commenter's support.
MIHS	For uniformity in all MIHS patient care programs, MIHS' draft sliding fee schedule policy contemplates two levels for patients with incomes above 100 percent of the FPG and not more than 200 percent of the FPG. R9-1-504(B)(4) and (C)(4) require at least three levels.	During a follow-up communication, the commenter stated that MIHS agrees to use a sliding fee schedule with three levels for patients with incomes above 100 percent of the FPG and not more than 200 percent of the FPG if required by the payer. The Department is not making any change to R9-1-504.

As a result of the public comment identified above, the Department revised R9-1-506(C) and (D). Subsections (C) and (D) as originally proposed stated:

C. If a provider uses a sliding fee schedule with fee percentages, an uninsured individual's fee for medical services shall not exceed the amount calculated by applying the fee percentage for the individual's family income to the balance remaining on the lowest contracted charge for each medical service provided that is not subject to payment under A.R.S. §§ 36-2907.05 or 36-2907.06.

D. If a provider uses a sliding fee schedule with flat fees, an uninsured individual's fee for medical services shall not exceed the balance remaining on the lowest contracted charge for each medical service provided that is not subject to payment under A.R.S. §§ 36-2907.05 or 36-2907.06.

In the supplemental proposed rules, subsections (C) and (D) now state:

C. If a provider uses a sliding fee schedule with fee percentages, an uninsured individual's fee for medical services shall not exceed the amount calculated by applying the fee percentage for the individual's family income to the lowest contracted charge for each medical service provided.

D. If a provider uses a sliding fee schedule with flat fees, an uninsured individual's fee for medical services shall not exceed the lowest contracted charge for each medical service provided.

In the supplemental proposed rules, the Department also made the following technical changes. The Department:

- Included the Department's rural private primary care provider loan repayment program within the sliding fee schedule requirement, as required in A.R.S. § 36-2174(A);
- Corrected the definition of "lowest contracted charge" by deleting the repetition of the word "service" in R9-1-501(26);
- Improved the definition of "provider" by changing R9-1-501(32)(b) from:
  Participates in a program that is authorized under A.R.S. §§ 36-104(16), 36-2907.06, or 36-2172, and that requires participants to use a sliding fee schedule;
  to:
  Participates in a program that requires participants to use a sliding fee schedule, such as a program authorized under A.R.S. §§ 36-104(16), 36-2907.06, 36-2172, or 36-2174;
- Added the word "single" to R9-1-506(A)(2) so that the subsection states: May charge an individual described in subsection (A)(1) only the single administrative fee determined according to subsection (E); and
- Added the word "single" to R9-1-506(E)(1) so that the subsection states: Establish a single administrative fee that does not exceed $25; and.

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

In fiscal year 2003, more than 30,000 uninsured individuals were determined eligible for the Department's primary care program, bringing the total number of individuals eligible for that program to more than 60,000. Qualifying community health centers contracted with the Department had a total of almost 50,000 visits billable to primary care program funds. For fiscal year 2004, the Department determined that it supports the primary care of nearly 50,000 uninsured individuals.

The Department's primary care program and other Department programs that call for a sliding fee schedule increase access to health care resources for the medically underserved. These programs increase the health care system's capacity to deliver services. Sliding fee schedules establish and limit the amount charged to uninsured individuals at or below 200 percent of the current federal poverty guidelines who receive services under the primary care program or from a provider serving the underserved through the primary care provider loan repayment program, the rural private primary care provider program, the J-1 visa waiver program, or the national interest waiver program. In the future, providers might be subject to a sliding fee schedule requirement under other programs.

For purposes of this preliminary economic impact summary, "minimal" means under $1000, "moderate" means $1000 to $10,000, and "substantial" means more than $10,000.

Uninsured individuals receiving medical services from providers subject to a sliding fee schedule requirement

Uninsured individuals receiving services covered by a sliding fee schedule benefit from no fees or reduced fees, according to the flat fees or fee percentages established by the schedule. The Department determined that sliding-fee-schedule providers must establish a $0 flat fee or a 100 percent reduction for uninsured individuals with family incomes at or below the current federal poverty guidelines. These uninsured individuals may be responsible for an administrative fee of $25 or less.

Based on a comment from the public, the Department determined R9-1-506(C) and (D) as originally proposed were difficult to understand. Therefore, the Department removed the phrases "balance remaining" and "that is not subject to payment under A.R.S. §§ 36-2906.05 or 36-2907.06" from the two subsections. It is possible that this change could result in increased fees for uninsured individuals with family incomes more than 100 percent of the current federal poverty guidelines but not more than 200 percent of the current federal poverty guidelines. However, the Department believes that any fee increase would be small.

For low income uninsured individuals, the cost of any fee assessed is offset by improved health status and quality of life for them and their families from the increased availability of health care. Increased availability of health care allows prevention or earlier diagnosis and treatment of medical conditions, decreasing the need for more costly treatments. Individuals who are responsible for a fee may place greater value on the services they receive. Additionally, individuals who share in paying for the services they receive may have enhanced self-esteem. Finally, a charge for services may reduce overuse of health care resources.

Providers subject to a sliding fee schedule requirement

Under the new sliding fee schedule rules, sliding-fee-schedule providers range from solo medical practices to non-profit organizations and county health departments. Excluding hospital inpatient services and medical services at a correctional facility or a detention facility generally limits the applicability of a sliding fee schedule to outpatient settings.

Under the new rules, sliding-fee-schedule providers will incur minimal to moderate staff-related costs for:

- Reviewing the annual update of the U.S. Department of Health and Human Services' Poverty Guidelines published in the *Federal Register*. The 2006 annual update is published at 71 FR 3848, January 24, 2006, and is available online at http://aspe.os.dhhs.gov/poverty/06fedreg.htm.
- Preparing annually a sliding fee schedule based on the updated Poverty Guidelines.
- Submitting the sliding fee schedule to the Department.

As under the rules as originally proposed, under the supplemental proposed sliding fee schedule rules, a sliding-fee-schedule provider can charge low income uninsured individuals at least the $25 administrative fee. The changes to R9-1-506(C) and R9-1-506(D) in the supplemental proposed rules might result in some increase in the fees chargeable by a sliding-fee-schedule provider to uninsured individuals with incomes above 100 percent of the federal poverty guidelines up to and including 200 percent of the federal poverty guidelines. The administrative fees and the fees calculated according to a sliding fee schedule can supply an important source of revenue for sliding-fee-schedule providers. The revenue from uninsured individuals' fees may enable facilities and providers to expand services. Additionally, the changes to R9-1-506(C) and (D) make the new rules more understandable and make sliding fee schedules easier for providers to use.

The Department

The Department annually incurs moderate to substantial costs to review sliding fee schedules submitted by facilities and individual providers. These costs result from the requirements in state statutes, state administrative rules, or federal regulations for a system of reduced health care fees for low income uninsured individuals.

The general public

Arizonans in general benefit from sliding-fee-schedule providers' reduced fees for low income uninsured individuals. Increased access to health care by the underserved, including low income uninsured individuals, allows for earlier and less expensive treatment and helps to control the total bill for health care in the state.

The benefits from the supplemental proposed sliding fee schedule rules will continue to outweigh the costs.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name:	Myriam Vega, Office Chief
Address:	Arizona Department of Health Services Office of Health Systems Development 1740 W. Adams, Room 410 Phoenix, AZ 85007
Telephone:	(602) 542-1219
Fax:	(602) 542-2011
E-mail:	vegami@azdhs.gov
Or	
Name:	Kathleen Phillips, Rules Administrator
Address:	Arizona Department of Health Services Office of Administrative Rules 1740 W. Adams, Room 202 Phoenix, AZ 85007
Telephone:	(602) 542-1264
Fax:	(602) 364-1150
E-mail:	phillik@azdhs.gov

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

The Department has scheduled an oral proceeding as follows:

ORAL PROCEEDING		
LOCATION	**DATE**	**TIME**
Arizona Department of Health Services 1740 W. Adams, Room 411A Phoenix, AZ 85007	June 9, 2006	2:00 p.m.

Until the close of record, a person may submit written comments on the proposed rules as changed in this Notice of Supplemental Proposed Rulemaking or on the preliminary economic, small business, and consumer impact summary to the individuals listed in items #4 and #9.

Persons with a disability may request a reasonable accommodation by contacting Lynn Golder at golderl@azdhs.gov or (602) 364-3958. Requests should be made as early as possible to allow sufficient time to arrange the accommodation.

CLOSE OF RECORD
5:00 p.m., June 9, 2006

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

12. Incorporations by reference and their location in the rules:

The Department is not incorporating any material by reference.

13. The full text of the changes follows:

TITLE 9. HEALTH SERVICES

CHAPTER 1. DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

ARTICLE 5. SLIDING FEE SCHEDULES

Section

ARTICLE 5. SLIDING FEE SCHEDULES

R9-1-501. Definitions

In this Article, unless otherwise specified:

1. "Administrative fee" means a fee payable by an uninsured individual that is established and charged according to R9-1-506(E).
2. "AHCCCS" means the Arizona Health Care Cost Containment System.
3. "Business day" means the same as in A.R.S. § 10-140.

4. "Calendar year" means January 1 through December 31.
5. "Child" means an individual under age 19.
6. "Consideration" means valuable compensation for something received or to be received.
7. "Correctional facility" means the same as in A.R.S. § 13-2501.
8. "Costs of producing rental income" means payments made by a rental-income recipient that are attributable to the premises or the portion of the premises generating the income, including payments for:
   a. Property taxes,
   b. Insurance premiums,
   c. Mortgage principal and interest,
   d. Utilities, and
   e. Maintenance and repair.
9. "Costs of producing self-employment income" means payments made by a self-employment-income recipient that are attributable to generating the income, including payments for:
   a. Equipment, machinery, and real estate;
   b. Labor;
   c. Inventory;
   d. Raw materials;
   e. Insurance premiums;
   f. Rent; and
   g. Utilities.
10. "Current federal poverty guidelines" means the most recent annual update of the U.S. Department of Health and Human Services' Poverty Guidelines published in the *Federal Register*.
11. "Deduction" means an amount subtracted from a payment, before an individual receives the payment, for:
    a. Federal income tax,
    b. Social Security tax,
    c. Medicare tax,
    d. State income tax,
    e. Insurance other than OASDI,
    f. Pension, or
    g. Other amounts required by law or authorized by the individual to be subtracted.
12. "Department" means the Department of Health Services.
13. "Detention facility" means a place of confinement, including:
    a. A juvenile facility under:
       i. A county board of supervisors, or
       ii. A county jail district authorized by A.R.S. Title 48, Chapter 25;
    b. A juvenile secure care facility under the Department of Juvenile Corrections; or
    c. A facility for individuals who are not United States citizens and who are in the custody of the U.S. Immigration and Customs Enforcement, Department of Homeland Security.
14. "Earned income" means work-related payments received by an individual, including:
    a. Wages,
    b. Commissions and fees,
    c. Salary,
    d. Profit from self-employment,
    e. Profit from rent received from an individual or entity, and
    f. Any other work-related monetary payments received by an individual.
15. "Family income" means the amount determined according to R9-1-503(B).
16. "Family member" means an individual, determined according to R9-1-502, whose income is included in family income.
17. "Fee percentage" means a part of a provider's usual charges for medical services that is:
    a. Expressed in hundredths, and
    b. Established by a provider in a sliding fee schedule for medical services rendered to an uninsured individual.
18. "Fetus" means the same as in A.R.S. § 36-2152.
19. "Flat fee" means a dollar amount that is:
    a. Established by a provider in a sliding fee schedule for a medical service or group of medical services rendered to an uninsured individual, and
    b. Less than the provider's usual charges for the medical service or group of medical services.
20. "Gift" means money, real property, personal property, a service, or anything of value other than unearned income for which the recipient does not provide consideration of equal or greater value.
21. "Hospital services" means the same as in A.A.C. R9-10-201.
22. "Income" means combined earned and unearned income.

23. "Inpatient services" means hospital services provided to an individual who is anticipated to receive the services for 24 consecutive hours or more.
24. "Interrupted income" means income that stops for at least 30 continuous days during the current calendar year and then resumes.
25. "KidsCare" means the children's health insurance program, a federally funded program administered by AHCCCS under A.R.S. Title 36, Chapter 29, Article 4.
26. "Lowest contracted charge" means the smallest reimbursement a provider has agreed to accept for a medical service:
    a. Determined by the provider's review of all the contracts between the provider and third party payors as defined in A.R.S. § 36-125.07(C), that:
        i. Cover the medical service, and
        ii. Are in effect at the time the medical service is provided to an uninsured individual; and
    b. Subject to limitations of federal or state laws, rules, or regulations.
27. "Medical services" means the same as in A.R.S. § 36-401.
28. "Medicare tax" means the amount subtracted from a payment for the health care insurance program for the aged and disabled under Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.
29. "New income" means income that begins at least 30 days after the start of the current calendar year.
30. "OASDI" means old age, survivors, and disability insurance.
31. "Profit" means the remainder after subtracting:
    a. The costs of producing rental income from the rent received from an individual or entity, or
    b. The costs of producing self-employment income from the self-employment income.
32. "Provider" means an individual or entity that:
    a. Provides medical services;
    b. Participates in a program that requires participants to use a sliding fee schedule, such as a program authorized under A.R.S. §§ 36-104(16), 36-2907.06, 36-2172, or 36-2174;
    c. Includes:
        i. A dentist licensed under A.R.S. Title 32, Chapter 11;
        ii. A physician licensed under A.R.S. Title 32, Chapter 13 or Chapter 17;
        iii. A registered nurse practitioner defined in A.R.S. § 32-1601 and licensed under A.R.S. Title 32, Chapter 15;
        iv. A physician assistant licensed under A.R.S. Title 32, Chapter 25 and practicing according to A.R.S. § 32-2531;
        v. A health care institution licensed under A.R.S. Title 36, Chapter 4; or
        vi. An office or facility that is exempt from licensing under A.R.S. § 36-402(3); and
    d. Excludes an individual or entity when the individual or entity provides:
        i. Inpatient services,
        ii. Medical services at a correctional facility, or
        iii. Medical services at a detention facility.
33. "Secure care" means the same as in A.R.S. § 41-2801.
34. "Self-employment" means earning income from one's own business, trade, or profession rather than receiving a salary or wages from an employer.
35. "Sliding fee" means flat fee or fee percentage that increases or decreases based on one or more factors.
36. "Sliding fee schedule" means a document containing a provider's flat fees or fee percentages based on:
    a. Family members determined according to R9-1-502, and
    b. Family income determined according to R9-1-503.
37. "Social Security tax" means the amount subtracted from a payment for OASDI under Title II of the Social Security Act, 42 U.S.C. 401 et seq.
38. "State health benefits risk pool" means:
    a. A state-established organization qualifying under 26 U.S.C. 501(c)(26);
    b. A state-established qualified high risk pool described in Section 2744(c)(2) of the Public Health Service Act, 42 U.S.C. 300gg-44(c)(2); or
    c. A state-sponsored arrangement, for which the state specifies the membership, primarily established and maintained to provide health insurance coverage for state residents with a medical condition or a history of a medical condition that:
        i. Prevents them from obtaining coverage for the condition through insurance or from a health maintenance organization, or
        ii. Enables them to obtain coverage for the condition only at a rate substantially more than the rate available through the state-sponsored arrangement.
39. "Support payment" means an amount, received at regular intervals by an individual, for food, shelter, furniture, clothing, and medical expenses.
40. "Terminated income" means income received during the current calendar year that stops and will not resume.
41. "Training stipend" means an amount, received at regular intervals by an individual, during a course or program for

the development of the individual's skills.

42. "Unearned income" means payments received by an individual that are not gifts and are not work-related, including:
    a. Unemployment insurance;
    b. Workers' compensation;
    c. Disability payments;
    d. Social Security payments;
    e. Public assistance payments, excluding food stamps;
    f. Periodic insurance or annuity payments;
    g. Retirement or pension payments;
    h. Strike benefits from union funds;
    i. Training stipends;
    j. Child support payments;
    k. Alimony payments;
    l. Military family allotments or other support payments from a relative or other individual not residing with the recipient;
    m. Investment income;
    n. Royalty payments;
    o. Periodic payments from estates or trusts; and
    p. Any other monetary payments received by an individual that are not gifts, are not work-related, and are not capital gains, lump-sum inheritance or insurance payments, or payments made to compensate for personal injury.
43. "Uninsured individual" means an individual who does not have health care coverage under:
    a. A group health plan as defined in Section 2792(a)(1) of the Public Health Service Act, 42 U.S.C. 300gg-91(a)(1), including a small employer's group health plan under A.R.S. Title 20, Chapter 13 or under the laws of another state;
    b. A church plan as defined in Section 3(33) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1002(33);
    c. Medicare, the health insurance program for the aged and disabled under Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.;
    d. Medicaid, the program that pays for medical assistance for certain individuals and families with low incomes and resources, through AHCCCS or another state's Medicaid agency, under Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., excluding a state program for distribution of pediatric vaccines under 42 U.S.C. 1396s;
    e. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or Tricare, the medical and dental care programs for members of the armed forces, certain former members, and their dependents under 10 U.S.C. 1071 et seq. and 32 CFR Part 199;
    f. A medical care program of the Indian Health Service or of a tribal organization;
    g. The Federal Employees Health Benefits Program for U.S. government employees, certain former employees, and their family members under 5 U.S.C. 8901 et seq. and 5 CFR Parts 890 and 891;
    h. Peace Corps plans under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e), including:
        i. Medical and dental care for Peace Corps applicants, Peace Corps volunteers, and minor children living with Peace Corps volunteers under 32 CFR 728.59;
        ii. Form PC-127C authorization for payment for evaluation of the Peace Corps related conditions of former Peace Corps volunteers;
        iii. Treatment of the Peace Corps related conditions of former Peace Corps volunteers under 32 CFR 728.53; and
        iv. CorpsCare coverage for the non-Peace Corps related conditions of former Peace Corps volunteers and their dependents.
    i. A state health benefits risk pool;
    j. An individual policy or contract issued by:
        i. An insurer for medical expenses, including a preferred provider arrangement;
        ii. A health care service organization under A.R.S. Title 20, Chapter 4, Article 9 or a health maintenance organization as defined in Section 2792(b)(3) of the Public Health Service Act, 42 U.S.C. 300-gg-91(b)(3); or
        iii. A nonprofit hospital, medical, dental, and optometric service corporation, a nonprofit hospital service corporation, a nonprofit medical corporation, or a nonprofit medical and hospital service corporation, including Blue Cross Blue Shield of Arizona, under A.R.S. Title 20, Chapter 4, Article 3, or organized under the laws of another state;
    k. An individual policy or contract made available through the Health Care Group of Arizona administered by AHCCCS under A.R.S. §§ 36-2912, 36-2912.01, and 36-2912.02;
    l. A health insurance plan of a state or of a political subdivision as defined in A.R.S. § 35-511 or determined under the laws of another state;
    m. A policy or contract issued to a member of a bona fide association as defined in Section 2791(d)(3) of the Public

Health Service Act, 42 U.S.C. 300gg-91(d)(3); or

n. KidsCare or another state's children's health insurance program under Title XXI of the Social Security Act, 42 U.S.C. 1397aa et seq.

44. "Variable income" means income in an amount that changes from payment to payment.

R9-1-502. Family Member Determination

A provider shall determine the family members of an uninsured individual seeking medical services.

1. A family with one member consists of:
   a. A non-pregnant child who does not live with:
      i. A parent;
      ii. A spouse;
      iii. An individual with whom the child has a common biological or adopted child;
      iv. A biological or adopted child; or
      v. A biological or adopted child of an individual with whom the child has a common biological or adopted child; or
   b. A non-pregnant individual over age 19 who does not live with:
      i. A spouse;
      ii. An individual with whom the individual over age 19 has a common biological or adopted child;
      iii. A biological or adopted child; or
      iv. A biological or adopted child of an individual with whom the individual over age 19 has a common biological or adopted child.
2. A family with two or more members consists of:
   a. An individual and:
      i. The biological or adopted children who live with the individual; and
      ii. If the individual or a child under subsection (2)(a)(i) is pregnant, each fetus;
   b. Two individuals, who have a common biological or adopted child and who live together, and:
      i. The common biological or adopted children living with the two individuals,
      ii. The biological or adopted children of either individual living with the two individuals; and
      iii. If an individual or a child under subsection (2)(b)(i) or subsection (2)(b)(ii) is pregnant, each fetus; or
   c. Two individuals, who are married to each other, who live together, and who do not have a common biological or adopted child, and
      i. The biological or adopted children of either individual living with the two individuals; and
      ii. If an individual or a child under subsection (2)(c)(i) is pregnant, each fetus.

R9-1-503. Family Income Determination

A. A provider shall establish flat fees or fee percentages for medical services rendered to uninsured individuals with family incomes, including earned and unearned income, equal to or less than 200 percent of the current federal poverty guidelines.

B. A provider shall determine an uninsured individual's family income by:
1. Multiplying a weekly payment received by a family member, before deductions, by 52;
2. Multiplying a biweekly payment received by a family member, before deductions, by 26;
3. Multiplying a monthly payment received by a family member, before deductions, by 12;
4. For variable income received by a family member:
   a. Adding at least four payments, before deductions;
   b. Dividing the sum obtained in subsection (B)(4)(a) by the number of payments included; and
   c. Multiplying the quotient obtained in subsection (B)(4)(b) by 52, 26, or 12 as appropriate;
5. Counting the actual payments received by a family member, before deductions, for:
   a. Interrupted income,
   b. New income, and
   c. Terminated income; and
6. Adding the amounts calculated under subsections (B)(1) through (B)(5).

R9-1-504. Sliding Fee Schedule Submission and Contents

A. By April 1 of each year, a provider shall submit to the Department the provider's sliding fee schedule, including:
1. A sliding fee schedule with fee percentages,
2. A sliding fee schedule with flat fees, or
3. A sliding fee schedule with fee percentages and a sliding fee schedule with flat fees.

B. A sliding fee schedule with fee percentages shall contain:
1. A statement that the sliding fee schedule applies to charges for all medical services provided to uninsured individuals by or through the provider;
2. The current federal poverty guidelines;
3. For an uninsured individual with a family income equal to or less than 100 percent of the current federal poverty

guidelines, a 100 percent reduction; and

4. For uninsured individuals with family incomes more than 100 percent of the current federal poverty guidelines but not more than 200 percent of the current federal poverty guidelines, at least three fee percentage levels that increase as family income increases.

C. A sliding fee schedule with flat fees shall contain:

1. The requirements listed in subsections (B)(1) and (B)(2);
2. The flat fee amounts for each medical service or group of medical services;
3. For an uninsured individual with a family income equal to or less than 100 percent of the current federal poverty guidelines, a $0 flat fee for each medical service or group of medical services included under subsection (C)(2); and
4. For uninsured individuals with family incomes more than 100 percent of the current federal poverty guidelines but not more than 200 percent of the current federal poverty guidelines, at least three flat fee levels that increase as family income increases for each medical service or group of medical services included under subsection (C)(2).

R9-1-505. Sliding Fee Schedule Approval Time-frames

A. The overall time-frame described in A.R.S. § 41-1072(2) for a request for sliding fee schedule approval is 32 days.

1. A provider and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame.
2. An extension of the substantive review time-frame and the overall time-frame shall not exceed eight days.

B. The administrative completeness review time-frame described in A.R.S. § 41-1072(1) for a request for sliding fee schedule approval is 11 days, beginning on the day the Department receives the request.

1. Except as provided in subsections (B)(3) and (B)(4), the Department shall mail to a provider a written notice of administrative completeness when the provider's request for sliding fee schedule approval is complete.
2. If a request for sliding fee schedule approval is incomplete, the Department shall mail to the provider a written notice of incompleteness that:
   a. Lists the missing documents or incomplete information, and
   b. Suspends the administrative completeness review time-frame and the overall time-frame from the postmark date of the notice of incompleteness:
      i. Until the date the Department receives a complete request for sliding fee schedule approval; or
      ii. For 60 days, whichever comes first.
3. If the Department does not receive all the additional documents or information required under subsection (B)(1) within 60 days after the postmark date of the notice of incompleteness, the Department deems the request for sliding fee schedule approval withdrawn.
4. If the Department approves a sliding fee schedule during the administrative completeness review time-frame, the Department does not issue a separate written notice of administrative completeness.

C. The substantive review time-frame described in A.R.S. § 41-1072(3) for a request for sliding fee schedule approval is 21 days, beginning on the postmark date of the Department's notice of administrative completeness under subsection (B)(1).

1. The Department shall mail to a provider a written notice of sliding fee schedule approval or disapproval according to A.R.S. § 41-1076 by the last day of the substantive review time-frame and the overall time-frame.
2. If the Department issues to a provider a written request for additional information according to A.R.S. § 41-1075(A), the request for additional information suspends the substantive review time-frame and the overall time-frame from the postmark date of the request for additional information:
   a. Until the date the Department receives all the information requested; or
   b. For 60 days, whichever comes first.
3. If the Department does not receive all the information requested under subsection (C)(2) within 60 days after the postmark date of the request for additional information, the Department shall disapprove the sliding fee schedule.

D. If a time-frame's last day falls on a Saturday, a Sunday, or a state service holiday listed in A.A.C. R2-5-402, the Department considers the next business day the time-frame's last day.

R9-1-506. Fees Payable by Uninsured Individuals Under a Sliding Fee Schedule

A. A provider:

1. Shall not charge an uninsured individual with a family income equal to or less than 100 percent of the current federal poverty guidelines the fee determined according to subsection (C) or subsection (D), and
2. May charge an individual described in subsection (A)(1) only the single administrative fee determined according to subsection (E).

B. A provider may charge an uninsured individual with a family income more than 100 percent of the current federal poverty guidelines but not more than 200 percent of the current federal poverty guidelines the fee determined according to subsection (C), subsection (D), or subsection (E).

C. If a provider uses a sliding fee schedule with fee percentages, an uninsured individual's fee for medical services shall not exceed the amount calculated by applying the fee percentage for the individual's family income to the lowest contracted charge for each medical service provided.

D. If a provider uses a sliding fee schedule with flat fees, an uninsured individual's fee for medical services shall not exceed

the lowest contracted charge for each medical service provided.

E. A provider may:

1. Establish a single administrative fee that does not exceed $25; and
2. Charge the administrative fee to:
   a. Uninsured individuals with a family income equal to or less than 100 percent of the current federal poverty guidelines; and
   b. Uninsured individuals with family incomes more than 100 percent of the current federal poverty guidelines but not more than 200 percent of the current federal poverty guidelines only in lieu of the fee calculated under subsection (C) or subsection (D).